State of Montana
Developmental Disabilities Program
Social History
Do not alter this form

DPHHS CM-1
Rev. 2-10-2010

Case Manager:	Phone:	Date Completed:

INDIVIDUAL INFORMATION:

Name: _____

Social Security Number: _____

Address: _____
_____

Phone: _____

DOB: _____ **Sex:** _____

Height: _____ **Weight:** _____

Marital Status: _____

Spouse Name: _____

Legal Guardian: _____

Relationship to Person: _____

Guardian Address: _____
_____

Guardian Phone: _____

Medicaid Number: _____

Medicare Number: _____

Burial Fund: _____ **Yes** _____ **No**
Trust Fund: _____ **Yes** _____ **No**
Life Insurance: _____ **Yes** _____ **No**

Primary Disability:

Diagnostic Code:

Secondary Disabilities:

Primary Doctor/Dentist:
Doctor: _____ **Phone:** _____
Dentist: _____ **Phone:** _____

Other Doctors/Counselors Involved:
_____ **Phone:** _____
_____ **Phone:** _____
_____ **Phone:** _____

Hospital Preference: _____
Phone: _____

Insurance Name/Address: _____
_____

Group #: _____
Policy #: _____

REFERRAL SOURCE:

NAME	RELATIONSHP	ADDRESS	PHONE

FAMILY AND SIGNIFICANT OTHERS TO CLIENT IN PRIORITY OF EMERGENCY CONTACT:

NAME	RELATIONSHP	ADDRESS	PHONE

FAMILY INTEREST: ____ **Strong Interest** ____ **No Contact** ____ **Some Interest** ____ **No Known Relatives**

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FINANCIAL: **(check those that apply)**

TYPE	RECEIVES & AMOUNT	HAS APPLIED FOR	DENIED
Medicaid			
Social Security			
SSI			
Medically Needy			
Other			

Name of Payee: _____

Current Services and Supports and/or Educational/Vocational Status:

Services Desired:

_____ **Check here if serious maladaptive behaviors.** (Describe in #10 of Social History)

_____ **Check here if serious medical problems.** (Describe in #5 & #6 of Social History)

SPECIAL AIDS OR EQUIPMENT USED: (if any of the following are used/needed, indicate by a check mark (✓).

	Walker		Hearing Aid		Manual Wheelchair		Artificial Limbs
	Cane		Special Bed		Ileostomy Equipment		Head Protective Device
	Crutches		Special Chair		Colostomy Equipment		Positioning Equipment
	Brace/Splint		Feeding Tube		Gastrostomy Equipment		Communication Aid
	Glasses		Catheter (Bladder)		Belly Board		Special Eating Utensils
	Dentures		Electric Wheelchair		Orthopedic Shoes		Other (specify):

MEDICATIONS: List the medications the individual receives and reason (e.g. behavior control, seizure):

Medication	Reason

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1. Describe individual's current living arrangement.

2. Describe where the individual was born and spent formative years, and when the primary/secondary disability was first noted by family and doctor. Describe any significant events that have occurred in his/her life.

3. List education, special education and related services provided to the individual, including all residential placements outside the family home with dates of placements.

4. List other agencies in which the person is or has been involved (current and past) with the phone number and name of a contact person for each agency.

5. Describe the current medical status and history for the individual including: allergies, medical/dental limitations, recent hospitalizations and surgeries, special diet, nutrient requirements, the need for invasive procedures, high blood pressure, etc. If possible, summarize the results of physical examinations, OT, PT, speech, nutritional and other pertinent evaluations.

6. Describe how often individual needs medical/mental health services.

7. Describe ability level of the individual, noting the areas in which he/she does well (strengths) and the areas he/she needs assistance and further training.

8. Describe individual characteristics of the person including such things as preferred learning style, events which may upset him/her, unique sense of humor, long/short-term retention, reading/writing skills, mode of communication, etc.

9. A. Describe the areas of vulnerability and risk to the individual. (e.g. sexual, financial, safety, etc.)

B. Is there a potential that the individual will abuse others or engage in illegal acts? Explain:

10. Describe in detail serious and minor problem behaviors that the individual currently exhibits or has exhibited in past. (Complete and attach the Behavioral Supplement when significant behaviors exist.)

11. Describe any alternatives available in the person's home community (if that is the person's desired place to live) and the status of attempts to secure those alternative services or supports.

12. Describe vocational interests and employment history of the individual (e.g. time on task without

supervision, response to supervision, etc.)

13. List future goals, plans and/or dreams that this individual has.

14. List hobbies, other leisure time activities as well as social and recreation activities in which the person likes to participate given the opportunity to plan his/her free time.

15. List any environmental, cultural, spiritual, or other factors important to assisting the individual in a placement.

16. Provide recommendations for services and/or supports noting any special considerations such as medical services, peer/support group considerations, need for communication devices, recreational interests, etc.

17. Explain the impact for the individual if services are not received.

18. Provide the case manager's assessment concerning the individual's need, (frequency of contacts, intensity, etc.) for case management services. (Actual case plan is on DPHHS-CM-3 or IP)

Individual completing intake and social history:

Case Manager Signature	**Date**
Case Manager Supervisor Signature	**Date**